Cavan / Monaghan Mental Health Service

A Model for a New Community Mental Health Service

THE CAVAN / MONAGHAN PROJECT
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A MODEL FOR A NEW COMMUNITY MENTAL HEALTH SERVICE
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This Monograph was prepared for the conference “Planning for New Community Mental Health Services in Ireland” held in the Slieve Russell Hotel, County Cavan on 25th and 26th of September 2001.

It details the radical changes in service structure and delivery that have taken place since 1998. While the new services await full evaluation, early assessment has shown that they are well accepted by patients, carers and health care staff.

The outcome of this project will be of significance for national Mental Health Service Planning.
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INTRODUCTION

I am pleased to be able to continue my association with the innovative pilot work in our mental health services through this introduction to the monograph. The monograph is an important way of recording 'what happened' in the transition to the new service and aims to provide a clear pathway for others to follow in the development of their mental health services.

The history of mental health services in Monaghan and Cavan has been closely linked to the move from the old psychiatric institution of St. Davnet's Hospital to developed community based services. More recent development of the acute psychiatric unit in Cavan General Hospital has enhanced services across the two counties. These developments have been led by a committed local management team, seeking to implement in a real way 'Planning for the Future' the national strategy for mental health published in 1984. The innovative pilot service in place since 1998 is an important extension of the progress made to improve community mental health services and raises some important questions about the relevance of the 1984 strategy to-day.

The model discussed in this monograph is based on an analysis of evidence and good practice elsewhere, coupled with a pragmatic solution based approach which meets the assessed needs of Monaghan and Cavan.

Four factors have made for the success of this service:

- Vision
- Commitment to evidence base and research
- Ownership across a range of disciplines
- Setting the service development in a strategic context.
The vision for the new service was developed by local mental health management, with the active support of senior health board management, an essential partnership if the resource requirements and change process was to be successful.

There has been a long history of research in the Cavan/Monaghan Mental Health Service and a commitment to see best practice and evidence from elsewhere as assisting the change process. The grateful support from various benefactors for research in mental health in Cavan/Monagha has allowed an extensive research programme to develop. The innovative service now provides rich research data for the future.

Most impressive has been the ownership of the new service by staff from across a range of disciplines. The initial commitment to examine other models of service in a practical ‘hands on’ way has provided valuable experience of other systems which staff were able to discuss and adapt to meet the service requirements in both Monaghan and Cavan.

The strategic context being developed by the Health Board, culminating in Board agreement to a mental health strategy in December 1999, provided a further building block on which to ground this new service.

This monograph sets out our model for a genuine community based mental health service without an over reliance on acute in-patient facilities. Its strength is the range and intensity of staff skills brought to bear to meet individual acute and rehabilitation needs.

We welcome the critical examination by others who wish to adapt and develop this model to meet their own service needs. We have set a challenging agenda to develop a community based mental health service
which provides support and assistance to individuals in their own houses and communities.

North Eastern Health Board management are committed to continue to support this innovative service development. We will argue at the highest level for the continued development of additional funding for this service so that it can continue to deliver a high quality community based service.

Finally, I would like to personally thank all those who have participated in bringing this new service to fruition; who took the risk to develop the vision to work in a different way. Their commitment has provided them with a rich reward.

Geoff Day
Assistant Chief Executive Officer.

September 4th 2001
1. HISTORICAL BACKGROUND

The development of psychiatric services in Ireland has mirrored the developments taking place internationally. There has been a move from institutional to community care and a marked decline in hospitalised morbidity. This decline has resulted primarily from the reduction in numbers of long-stay patients. At the same time, however, admissions to mental hospitals have risen substantially, placing considerable pressure on acute psychiatric beds. A phenomenon has developed of rapid turnover, with a cycle of readmission, short length of stay and often-premature discharge, leading to further readmissions. As a result, services for patients can be unduly determined by availability of bed resources.

Central Planning

Fundamental issues relating to the delivery of Irish mental health services have not been well addressed. Ireland is unusual in its limited degree of central service planning. In the modern era there are only two national planning documents in mental health, The “Commission of Inquiry” into Mental Illness (1966) and “Planning for the Future” (1984). Both these documents promoted a move to community care. “Planning for the Future”, in particular, was a prescriptive document, describing in detail the mechanisms for phasing out traditional mental hospitals and placing considerable emphasis on the relocation of acute units in General Hospitals. It accelerated the phasing out of institutional psychiatry but gave little scope for the development of local service innovations. As a result, there has been considerable uniformity in the structure of national services. “Planning for the Future” is now 17 years old and can no longer respond to new developments in psychiatry, such as specialisation and advanced community models of care. A new national service strategy for mental health is long overdue.
Service Evaluation
Health research in Ireland has not focused on service evaluation. There is annual statistical data available on the use of existing resources. However, there has been little evaluation of the effectiveness of service programmes.

Mental Health Legislation
Mental health legislation in Ireland has not been given priority. A replacement for the 1945 Mental Treatment Act has only recently been enacted and commencement is still awaited. The practical implementation of this Act will be difficult if current levels of certification continue.

THE CAVAN/MONAGHAN EXPERIENCE

Service Background
St. Davnet’s Hospital was a traditional District Mental Hospital, established in 1869 and providing a psychiatric service for counties Cavan and Monaghan. Like most Irish District Mental Hospitals the inpatient numbers peaked in 1958. At that time the hospital accommodated 892 patients. St. Davnet’s Hospital was the first hospital in Ireland to adopt the emerging new model of community psychiatry. An active rehabilitation programme, targeting long-stay patients, was introduced in 1975. Over the next 20 years rehabilitated patients were discharged home, to supported group homes and 24-hour nurse-staffed hostels. A group of patients with Learning Disability were transferred to the care of the Learning Disability Service. A further group of socially disadvantaged, elderly patients were transferred to a Welfare Home. An active policy of minimising transfers to long-stay wards was introduced. Emphasis on the care needs of former and remaining long-stay patients was facilitated by the establishment of a core of specialist nurses with sessional input from a specific psychiatrist. These developments resulted in a substantial drop in hospitalised morbidity (Figure 1.1).
In the mid 1970’s the Cavan/Monaghan catchment (population 104,000) was sectorised into four sectors, each with an approximate population of 25,000. All admissions were to an admission unit at St. Davnet’s Hospital until an admission unit was established in the new Cavan General Hospital in 1990. This was planned as a 50-bed unit to provide for all admissions from Cavan and Monaghan. Opposition to the closure of the admission unit in Monaghan resulted in a 25-bed unit in Cavan for admissions from Cavan and retention of a 25-bed admission unit in St. Davnet’s Hospital for admissions from Monaghan. The separation of the two admission units resulted in a degree of separation in service provision.

A planned programme of mental health service research began in 1991. This programme looked at all aspects of service delivery. It became evident that existing practices were inefficient and were not answering individual patient needs. Resulting from this research fundamental changes were made in service structure and delivery. Central to these changes were the introduction
of specialisation, individualised multidisciplinary care planning, and a shift in the locus of care to patients' homes. These changes were achieved by a planned relocation of resources from the existing service, without allocation of extra funding.
2. SERVICE RESEARCH LEADING TO CHANGE

Mental Health Service development must be based on evaluation of the effectiveness of current services in answering patients' needs. In the Cavan/Monaghan service, a research programme was initiated to assess all service practices and the care needs of patient groups.

Summary of Research On Services For Patients With Severe And Enduring Mental Illness:

1. An analysis of a new long-stay population - the need for mental hospitals.
3. A long-term follow-up of rehabilitated patients with chronic psychiatric illness.
   *Hospital and Community Psychiatry.* 1996 October; 47 (10): 1120-1122
4. The characteristics of long-term day-care attenders in a rural Irish Mental Health Service.
   *Submitted: Irish Journal Of Psychological Medicine*
5. Assessment of Need in the community based chronically mentally ill.
   *Ongoing.*

Results of Research

1. "An analysis of a new long-stay population - the need for mental hospitals".
   This study found that in 1991 there was a requirement for new long-stay mental hospital beds of 32 per 100,00 for all age groups and 11.3 per 100,000 for those under 65. It revealed the need for four categories of patient care - geriatric care for the elderly frail with minimum behavioural problems; a
specialist geriatric unit for the psychiatrically disturbed elderly; specialist hostel care for the disturbed younger patient; and specialist hostel care for those with psychiatric impairment, but few behavioural problems. The paper emphasised the need to phase out institutional beds and establish appropriate alternative facilities in the community.

2. "Towards mental hospital closure: A study of a residual long-stay population".
This study analysed the needs of all remaining long-stay patients in St. Davnet's Hospital, to investigate the feasibility of hospital closure. It found that new and old long-stay patients required similar categories of residential facilities as found in the previous paper, but differed significantly in other care needs. It emphasised the necessity for ongoing, individualised care programmes.

3. "A long-term follow-up of rehabilitated patients with chronic psychiatric illness":
This paper analysed the outcome of former long-stay patients who had participated in the rehabilitation programme started in 1975. Two hundred and ninety seven patients were involved and all were traced. No patients were homeless or in poor quality accommodation. None had had prison contact. No patient had "fallen out of care". The mortality rate was lower than expected. Two community-based patients committed suicide over a 20-year period. The suicide rate was lower than similar published studies and can be contrasted with a figure of 8 inpatient suicides over the same period. Seventy six percent of patients were discharged and 80% of these maintained their community placement. The study emphasised the factors important in successful community placement: a range of supported community facilities; constant reassessment of patient need; and direct provision of care by the psychiatric services coupled with appropriate access to other health care and social services.
4. “The characteristics of long-term day-care attenders in a rural Irish Mental Health Service”.

This study used the MRC Needs for Care Assessment in assessing met and unmet needs in patients attending two Day Centres in Monaghan. Fifty four percent of the group was living in non-staffed group homes; the remainder was living at home. Forty one percent had previously been in long-stay care. The findings underlined the fact that the predominant needs, clinically and socially, were for assessment. Unmet social needs were more common than unmet clinical needs. The results highlighted the importance of a multidisciplinary approach in assessing and meeting the needs of chronically ill, community patients.

The findings from the service research programme suggested the need for a specialist, multidisciplinary rehabilitation service that would provide assessment and treatment for all patients with severe and enduring mental illness. These patients would include the remaining long-stay patients, the discharged long-stay patients and the new emerging chronically ill, currently being treated by generalist services.

Summary of Research On Services For Patients With Acute Psychiatric Illness

1. Involuntary admissions to a district mental health service - implications for a new mental treatment act.

2. An analysis of general practice referral behaviour to psychiatric outpatient clinics.

3. The ‘Whirling Door’ Phenomenon: A study of a Group of Very Frequently Readmitted Patients. *Submitted for publication*

4. Patients who Lapse from Outpatient Psychiatric Care. *Submitted for publication*
Results of Research

1. "Involuntary admissions to a district mental health service - implications for a new mental treatment act".

This study showed levels of certification in Cavan/Monaghan of 61.5 - 86.5 per 100,000 total population. These rates were equivalent to national rates but were very much higher than rates in neighbouring jurisdictions. The higher Irish certification rates were noted to be reflective of inappropriate use of certification as a response to alcohol related social crises. Of equal concern were the findings that 59% of certified patients were currently attending either their GP or the mental health service, with 48% of these attending the mental health service. Of those attending the mental health service, 66% had been seen within four weeks of certification and 30% within one week. The study described a service limited in its ability to respond to acute relapse in ways other than certification.

2. "An analysis of general practice referral behaviour to psychiatric outpatient clinics".

This study showed referral rates to specialist psychiatric services in Monaghan of 3.2 per 1000 population per year. This rate was similar to the national rate of 3.4 but was significantly lower than rates in Northern Ireland, England and Wales. There was a significantly increased referral rate from GPs with vocational training in psychiatry and a tendency for lower referral rates from group practices. There were very marked variations in levels of referral from different practices, varying from 2.4 to 12.5 per 1000 adult GMS patients per year. GP referral behaviour is crucial in defining psychiatric practice. This study confirmed the need for much closer relationships between the psychiatric and primary care services, with appropriate protocols governing referral practice.

This study analysed the factors associated with high readmission rates to the acute unit at St. Davnet’s Hospital. It examined all admissions over a 5-year period and identified those who had six or more admissions in any twelve-month period. Thirty-four patients were identified. This equated to 4.6% of all patients admitted, 23.6% of all admissions and 18.3% of occupied bed days. Forty seven percent of the identified group had Bipolar Mood Disorder and 25.5% had Schizophrenia. The group had high rates of non-compliance and social handicaps. Sixty seven percent were repeatedly “self referred”. A picture emerged of a failure to recognise and address the individual problems of the patients involved. There appeared to be a stereotyped “readmission response”, despite the obvious clinical failure of previous admissions.

4. “Patients who Lapse from Outpatient Psychiatric Care”.

The main finding from this study was the very high drop-out rate by patients using outpatient clinics. Fifty three percent of new referrals dropped out during the two-year study period. Sixty six percent of these had lapsed by the fourth visit. Unemployment and having associated alcohol abuse were significantly related to lapsing. No other patient characteristics predicted lapsing. The evidence was of a psychiatric service that was not adequately managing its outpatient activity.

The aggregate of these studies described a service that continued to base its treatment responses on traditional structures and practices, and which tolerated inordinate use of compulsory admission. The studies indicated the need for a fundamental reorganisation of service delivery to include:

1. Flexibility in responses to patients’ needs and preferences
2. A more community-based service with closer links to primary care
3. The adoption of home-based treatment programmes for acute illness as an alternative to hospitalisation.
3. FACILITATING CHANGE IN THE MENTAL HEALTH SERVICE

The prime responsibility of a Psychiatric Service is to address the needs of individual patients. To do this effectively, services must be appropriately structured. The structure of traditional services, however, makes it difficult to provide this essential, individual focus. Inpatient units have priorities that frequently conflict with individual patient needs. This is evident from the results of many studies that reflect patients' dissatisfaction with their inpatient experiences. Outpatient activities are restricted by the large numbers attending and the lack of opportunity for multidisciplinary assessment. Day Hospital and Day Centre programmes are rarely flexible enough to accommodate individual needs, so that patients must adapt to programmes rather than programmes adapting to patients. Overall, the limited availability of specialist services inhibits accurate patient assessment and quality treatment response.

The consequences of inadequacies in the nature of service provision are evident in high readmission rates, high certification rates and high lapsing rates at outpatient clinics. The mental health care system, as currently organised, contributes to ongoing short-term clinical assessments in what, for many patients, may be long-term illness. It encourages tendencies to see patients more in terms of their diagnosis than as individuals with illness. Similarly, it encourages over-reliance on medication and admission as solutions to patient problems. The locus of treatment, confined as it is to specific service locations, limits awareness of the reality of patients' every-day lives.

Initiation of Change in the Cavan/Monaghan Mental Health Service

In the absence of a modern national service plan, Cavan/Monaghan agreed a new service model, based on local research and a review of relevant models abroad.
The new services were founded on the following principles:

- The centrality of patient's needs and rights
- Specialist services for specific patient groups
- The delivery of individualised effective treatment packages in the setting of home and family
- Minimum use of inpatient beds

Three categories of specialist services were considered appropriate:

- A Community Mental Health Team with Home-Base Treatment,
- A specialist service for patients with severe and enduring mental illness - the Community Rehabilitation Team
- A specialist Psychiatry for the Elderly Service

Factors Inhibiting Change

Various factors inhibit change in the Mental Health Service. These include a failure to recognise the inadequacies of the present care systems; different perspectives between clinical and non-clinical managers; the reluctance of professional groups to accept responsibility for initiating change; the belief that service change requires substantial extra funding.

Recognising the Need for Change

The service research programme in Cavan/Monaghan indicated the need for radical change spanning the whole range of mental health service provision. The urgent need for these changes was recognised by the Catchment Management Team and senior clinical staff.

A Shared Perspective

The Cavan/Monaghan Catchment Management Team reviewed the results of the service research studies and agreed the service changes required. Senior professionals were approached and contributed to the plan for change. This
involvement of key staff was central to the eventual success of the service reorganisation programme.

**Professional Groups**

All professional groups have certain rigidity in work practices. While these are understandable in the setting of legitimate professional needs, they can inhibit the development of more effective services and be restrictive in the development of the professions themselves.

The involvement of nursing staff is central to change, in that they form the predominant clinical resource in the mental health service. Traditional services can place considerable constraints on their professional development and restrict their therapeutic input. The new service models require substantial change in the professional role of psychiatric nurses. Multidisciplinary team-working, Home-Based Treatment and Assertive Outreach Nursing all require nurses to carry greater clinical responsibility and autonomy. Nursing is now becoming a graduate profession and this will be helpful in confirming their clinical independence. Training programmes in nursing will need to recognise this and provide experience in working in advanced community services. There will also be a continuing need to develop specialism within psychiatric nursing, particularly in the areas of social and psychological therapies. The experience in Cavan/Monaghan is that nursing staff adapt very well to these demanding but more professionally rewarding roles.

Other professional groups have also been able to adapt to true multidisciplinary working and case sharing. The training programmes of psychologists, social workers, occupational therapists and other therapists will need to include specific modules to enable them to participate in the more sophisticated team-working required in the new psychiatric service.
The experience of the new Cavan/Monaghan Service shows that there is a need for greater input at consultant psychiatrist level than in traditional services. By definition, the services treat more severely ill patients in the community. This requires the immediate availability of consultants. Even allowing for specialism in Psychiatry of the Elderly and Rehabilitation Psychiatry, the experience in Cavan/Monaghan suggests that safe clinical systems require a minimum of one consultant in General Psychiatry for 15,000 total population. These manpower requirements can only be met in the context of a comprehensive, manpower-integrated, nationally-based consultant training programme that emphasises experience and training in multidisciplinary team-working and management skills.

Resources

Cavan/Monaghan is not anomalous in psychiatric resource. The level of resource available within the psychiatric services is largely a reflection of historical spending. Areas that had large mental hospitals still have substantial funding. The redeployment of this resource requires vision and commitment on the part of management and clinical staff.

Beds still predominate in clinicians' perspectives on treatment. Most consultant psychiatrists are still based in units that include acute beds. Community Mental Health Centres, rather than inpatient units, are the appropriate base for the delivery of community mental health services. Such centres emphasise community options for treatment and facilitate multidisciplinary team working. Many of the negative features associated with current outpatient psychiatric clinics can be remedied in this situation. Mental Health Centres need to be well designed and of adequate size.

Little additional resource was available for the reorganisation of services in Cavan/Monaghan. Staff were appointed to the new clinical teams following internal advertisement. Nursing staff availability had been facilitated by the
closure of two long-stay wards in 1995 and 1998. The new services led in turn to the closure of yet another ward in 2000. This third ward closure facilitated improved staffing on the new teams. While extra funding was not made available there was, for a period, some over-run of the established nursing number.
4. SERVICES FOR THE SEVERLY MENTALLY ILL
THE COMMUNITY REHABILITATION TEAM (CRT)

The Specialist Service for the Severely Mentally Ill commenced in late 1998. Prior to this development, there had been a core staff group involved in caring for the long-stay patients in St. Davnet’s hospital and the discharged long-stay patients resident in staffed hostels and group homes.

A number of priorities were identified for the new service. These included the development of a service protocol that would identify target patients and describe the aims and philosophy of the programme. A multidisciplinary team, predominantly community based, was required to reflect the range of patient needs already identified. Training was required to familiarise staff with specific assessment instruments and care interventions.

The aims, philosophy and target groups of the service were defined as follows:

**Aims**

- To enable patients with severe and persisting mental illness to reach their highest possible level of functional independence.
- To provide the level of care and support to such patients that is appropriate to their disablements.
- To provide the informal carers of such patients with the knowledge, skills and support necessary to assist them in their caring role and to minimise the stress associated with that role.

**Philosophy**

The core philosophy of the service was to provide individualised care programmes for patients and carers, based on identified need and implemented as much as possible in a non-institutional setting.
Target Groups:

- All patients with a severe and persisting mental illness, who as a result of that illness, suffer disabling effects in their psychosocial adjustment, particularly in the areas of refractory symptoms, personal care, social skills, vocational/recreational skills or residence and whose needs cannot be met at the level of the Sector Service.
- The families or informal carers of such patients.

The definition of target patients included the remaining long-stay patients in St. Davnet’s Hospital (excluding the very elderly), the discharged long-stay patients and the new chronically ill, whether in hospital or in the community.

In September 1998, the first members of the developing Assertive Outreach Nursing Team were assigned. This allowed the CRT to take responsibility for patients in the acute unit in St. Davnet’s Hospital who met the service criteria. As the multidisciplinary, community-based staffing of the team increased, it became possible to begin taking additional referrals from the Community Mental Health Team.

Structure of the Community Rehabilitation Team:

By June 2001, the staffing of the Community Rehabilitation Team had reached the following levels:

- ACNO Team Coordinator
- Team Secretary
- Consultant Psychiatrist
- Senior Registrar
- Registrar
- Community based Continuing Care Nurses: 2
- Assertive Outreach Nurses: 11
- Cognitive Behaviour Therapist: 1
- Occupational Therapist 0.5
• Social Worker 0.5
• Domestic Science Therapist: Part-Time
• Community Domestic Staff: 3
• Support Day Centre Nursing Staff: 3
• Staffing of Residential Facilities:
• Staffed Hostel Nursing Staff:
• Long-stay Ward Nursing Staff:

Patient Case Load June 2001

• Long-stay Wards: 25
• 24-Hour Nurse Staffed Hostels: 46
• Supported Group Homes: 39
• Nursing Homes / Geriatric Care: 11
• Personal Residence: 30

SMI Service Facilities June 2001:

• (Inpatient Rehabilitation Unit closed September 2000)
• Rehabilitation Support Centre: 1
• Long-stay Wards: 2
• 24 Hour Nurse Staffed Hostels: 4 with 51 places.
• Group Homes: 11 with 40 Places

Additional Community Facilities which can be accessed:

• Industrial Therapy Department: 20 places.
• Rehabilitation Workshops.
• NRB Placement Services.
• FAS and Community Employment Schemes.
Working Protocol For the CRT Service:

As both patients and staff of the Community Rehabilitation Team are located in many areas, effective team communication is a central component of efficient team working. A weekly Team Meeting occurs, attended by staff from the community, Support Centre and Long-stay Wards. A six-weekly staffed hostel meeting occurs, attended by hostel staff and representatives of community staff.

The protocol for patient care in the Community Rehabilitation Service includes:

- Referral
- Assessment
- Programme Design
- Programme Implementation
- Programme Review

The service takes referrals only from within the psychiatric service. Referrals are made through the team coordinator and are discussed at the weekly Team Meeting. Assessment is detailed. It includes an in-depth medical assessment of illness history, medication history and current symptomatology. This is followed by assessment of personal skills, social and vocational functioning and informal support structures. Standardised assessments instruments are used, including the Community Placement Questionnaire (CPQ), the Functional Assessment of the Care Environment (FACE), and needs assessment using the MRC Need for Care or the Camberwell Assessment of Need.

Care Plans are drawn up by relevant team members once assessments are completed. Where possible, the patient is involved. Care Plans have six main sections: risk status, crisis management, physical health monitoring, management of acute relapses, problem intervention and details of care plan.
implementation. A Key Worker is assigned to each patient, whose task is to coordinate the patient's care and serve as the first point of contact for the patient or his/her family in a crisis.

The service protocol is being applied to all new referrals and, on a phased basis, to all existing patients of the service. The initial assessment and care planning is time consuming, but provides a comprehensive understanding of the patient's history and circumstances which sets the foundation for rational care planning in the future.

**The role of the Assertive Outreach Team:**
The Assertive Outreach Team takes responsibility for all new referrals to the CRT. They have also taken over the care of a number of discharged long-stay patients who have particularly complex needs. Input from the team is based on the individual care plans and is sufficiently flexible to address a wide range of needs and to respond promptly to crises. The locus of care is primarily in the patients' home, with specific modules of care being provided, as required, by the Support Centre. Care inputs include:

- Monitoring overall level of functioning to predict signs of relapse
- Symptom and side-effect monitoring
- Medication compliance, including daily home visits if necessary
- Encouragement and facilitation of personal hygiene
- Dietary advice and monitoring
- Monitoring physical health status and facilitation with attendance at GP or specialist clinics
- Education on home-making skills and assistance with budgeting, in conjunction with Psychiatric Social Worker
- Monitoring adequacy of housing, in association with Psychiatric Social Worker
- Addressing work and leisure needs, in association with Occupational Therapist
Family education and support
Liaison with outside agencies including Community Care, Solas Advocacy Group, Employment Support Schemes.
The Assertive Outreach Nursing service is available 8 am to 6 pm seven days a week.

The Rehabilitation Support Centre

In 1995, a ward of the hospital was refurbished to function as an inpatient rehabilitation unit. From 1998 patients taken on referral from the CMHT who needed specific rehabilitation programmes were admitted there. The ward also provided respite accommodation for patients in the programme. However, following the availability of a multidisciplinary community team, it became possible to discharge all patients to suitable community residences. It was also found that it was preferable to have the focus of care and rehabilitation programmes for the "new" chronically ill based in their homes as much as possible. Given these developments, in September 2000, the inpatient rehabilitation unit closed and was transformed into a Support Day Centre and Team Headquarters. Two places were made available in a staffed hostel to replace the respite function previously provided by the unit.

The Support Centre does not function as a traditional Day Centre, but provides flexible support to patients of the programme. The Centre is open seven days a week from 7.30am until 9.30pm with nursing staff available to any patient of the programme who requires advice or support. The majority of those who attend do so for specific modules of care. Patients in crisis, or who require additional supervision or support may attend daily for a period.

Acute Relapse

Patients who require inpatient treatment for an acute relapse of illness are admitted to the acute admission unit, but remain under the care of the Community Rehabilitation Team.
5. SERVICES FOR THE ACUTELY MENTALLY ILL
THE COMMUNITY MENTAL HEALTH TEAM
(CMHT)

The Monaghan Community Mental Health team was established in September 1998, with the Cavan Team becoming operational in 1999. The impetus for this development came from service evaluation of the acute mental health services. There were a number of key findings in this research. GP referral rates were low by international standards. There were high rates of readmission, with a core group of "revolving door" patients whose needs were obviously not being met. Certification rates were high, again by international standards, and there was evidence of inappropriate use of certification. There were high levels of lapsing from standard outpatient clinics, with inadequate follow-up procedures.

A decision was taken that a new service model was required to treat acute mental illness. This model would provide:

- One point of access for all acute referrals to General Psychiatry
- Multidisciplinary assessment of all referrals
- Individual Care Plans
- Allocation of Key Worker to patients
- Integrated and shared case management
- Close working relationships with GPs
- Liaison with voluntary organisations, self-help groups, carers' groups and community groups
- The development of a Home-Base acute nursing service as an alternative to the use of admission beds

The aims of the CMHT are to provide an integrated, comprehensive, high quality, individualised system of care and support which meets the needs of people with acute mental health problems.
The Structure of the CMHT

- ACNO Team Coordinator
- Consultant Psychiatrist
- Senior Registrar
- Registrars: 3
- Addiction Counsellor: 1
- Community Psychiatric Nurses: 2
- Social Worker: 0.75
- Occupational Therapist: 2
- Family Therapists: 2
- Psychologist: 1
- Behaviour Therapist: 1
- Home-Base Treatment Team
- Nursing Staff: 6
- Community Support Worker: 1
- Secretary: 2
- Inpatient Unit: 16 Nurses

Associated Service:
- Addiction Resource Centre: 6 Counsellors

The working of the CMHT

Referrals are predominantly from GPs. All referrals are to the Team Coordinator who operates a role of screening and triaging. Referrals are discussed at a full meeting of the CMHT where agreement is reached on the appropriateness of referral and the professional group deemed most suitable to provide treatment. This practice involves new referrals not necessarily being seen by a medical member of the team. If referrals are not thought to be appropriate for a specialist mental health service, alternative recommendations are made by phone to the GP. Emergency referrals are dealt with on a day-to-day basis, by contact between the referring agency, the
team coordinator, and the appropriate team members. Such referrals are seen within two hours. The consultant psychiatrist, as clinical leader of the team, is constantly kept informed by the team coordinator.

In addition to discussion of referrals, the team meeting also provides a forum for discussion of patients who present with special problems or who fail to respond to treatment as anticipated. These discussions are valuable in the elaboration of multidisciplinary programmes of treatment and in improving the skills and working relationships of team members. Outpatient services are closely monitored, with specific protocols on the response to lapsing. The team gives time to the discussion of relationships with primary care teams. It accepts a role in community mental health education programmes. There is ongoing discussion in relation to team effectiveness and the educational needs of team members. All team activities are recorded to enable effective audit.

Nursing staff on the acute admission unit are seen as part of the CMHT and senior nurses from the unit attend all team meetings.

**Home-Base Treatment Service**

The Home-Base Treatment Service is provided by a discrete functional nursing team operating within the CMHT, with appropriate input from other members of the multidisciplinary team. The service aims to provide a safe alternative to inpatient care for patients with acute mental illness and associated social crises. It provides this function through the delivery of focussed care plans drawn up following formulation of a diagnosis and treatment needs. Problems, needs and strengths of the patient and his family are assessed and care plans are agreed. These care plans are flexible and allow the team to respond rapidly to changes in clinical situations. Risk management plans are implemented and contractual arrangements agreed with patient and family in relation to number and frequency of home visits and types of clinical input. These plans allow the patient to have emergency
access to the psychiatric service at all times. The Home-Base Treatment Team
operates on a 9 am to 9 pm basis seven days a week. Emergency contact
outside these hours is to the on-call service at St. Davnet's Hospital. The
working of the Home-Base Team is facilitated by two formal meetings per
week. These are attended by the Home-Base nurses, the team coordinator, all
the medical members of the CMHT and any other relevant team members.
The nurse in charge of the admission unit also attends. Patients' GPs are kept
fully informed of the patients' clinical status.

The role of the Home-Base Treatment Nurse

- Coordinating the patient's care
- Supervising medication and monitoring side-effects
- The provision of supportive psychotherapy
- Education of the patient and his family on the nature of the illness and
  allaying fears regarding medication
- Advising and supporting patients and their families in illness related
daily living problems
- Evaluating the patient's ongoing clinical condition and informing the
  supervising psychiatrist on the need for treatment review

Referrals to the Home-Base Treatment Service are made on a formal basis
following joint assessment by a psychiatrist and a member of the Home-Base
Team. The team coordinator and consultant psychiatrist are informed. The
case-load is regularly reviewed and patients referred back to other members
of the CMHT for appropriate follow-up. If necessary, patients are admitted to
the acute unit.
6. MENTAL HEALTH SERVICES FOR THE ELDERLY

Background
The Cavan/Monaghan Mental Health Service for the Elderly is a rural based service. Distances between the furthest points in both counties exceed 40 miles. The catchment area has been described as “demographically disadvantaged, with thinly dispersed population and poor public transport.” The percentage population over 65 years is 13.5% compared with a national average of 11.4%. This discrepancy is more marked in Cavan at 14.5% compared to 13% in Monaghan. Old age dependency ratios are higher in Cavan where there is also a significant gender imbalance.

The Mental Health Services for the Elderly Team was formed in January 2000 following the appointment of a Consultant Psychiatrist in November 1999. The team was formed amid a culture of changing practice in Psychiatry in the area, with the development of community-based Mental Health Teams, Home-Base Treatment Teams and multidisciplinary team working. Staff provision was generous. This came about as a consequence of redeployment of resources enabled by the closure of long-stay units at St Davnet’s Hospital with consequent freeing up of staff, and a commitment by the Management team to the provision of a comprehensive community model for all branches of the mental health service.

Patient Groups
The groups of patients most appropriately dealt with by Psychiatry of Old Age Services have been described as follows:

1. Elderly people developing functional psychiatric disorders for the first time over the age of 65 years
2. Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.
This narrow definition does not, however, take account of other groups of older persons who have special needs such as the "graduate" population. Early diagnosis of dementia and prescription of anti-dementia drugs may be another target area.

**Team Structure**

The Community team consists of One Co-ordinator (ACNO); four Home-based nurses for each county including one CNM 2 in Cavan and one CNM 1 in Monaghan and one Support Worker in each county. Other staff include one Social Worker, 0.5 WTE Occupational Therapist, one Behaviour Therapist and two Secretaries. Medical staff consists of one Consultant and one SHO/Registrar. A Senior Registrar post has been funded and is awaiting approval.

A Day Hospital at St Davnet's Hospital has the following facilities and staff: ten places per day, one team leader (CNM 2), three staff nurses, one support worker. Acute admission facilities are in the Psychiatric Unit at Cavan General Hospital.

**Activities of the Service**

The service saw 245 referrals during the year 2000 (February to December). Over 90% of these patients had a diagnosis of depression or dementia. There were 140 referrals in Cavan, 75 GP referrals for community-based patients and 65 referrals for patients in hospital or residential care. There were 105 referrals in Monaghan, 80 for community dwelling patients and 25 consults, mainly in long-term care. The Day Hospital service was successfully established in St Davnet's Hospital with over 623 attendances from 42 patients. There were 17 acute admissions to Cavan General Hospital Psychiatric Unit. There have been frequent referrals to Social work and Behaviour Therapy.
The referral numbers for 2001 (to September 1 2001) have already exceeded the numbers for the year 2000. There are still more referrals in Cavan which can be accounted for by the larger Consultation-liaison commitment brought about mainly by being located on the General Hospital site rather than the slightly larger population of elderly persons in Cavan.

Model of Service Delivery
The traditional model of service delivery in the UK involves medical assessment in the home by medical staff. An alternative method of service delivery, popular in the US, involves the widespread use of outpatient department consultations. A third model has developed, using multidisciplinary community teams, where first assessments are carried out in the home, usually by non-medical member of the team.

Referrals
Referrals to the service are restricted to GPs and other Medical Staff. This is because GPs are pivotal in the care of elderly patients. If referrals come from Public Health Nurses, persons in charge of residential homes or other sources, the referring agent is asked to provide a letter from the GP outlining the current health status of the patient. Constant communication with the GP and Public Health Nurse is aspired to with the aims of avoiding duplication of assessments or services and providing a seamless service to all service users. Referrals are made to the Team Coordinator who triages the referral and arranges the initial assessment.

Conscious of the need to assess home circumstances in all cases and the desire to have an efficient service, the procedure of initial assessment by nursing staff was established. Standardised history taking documents and rating scales are used. All patients are subsequently seen by the medical staff either at home or at the hospitals (St Davnet's or Cavan General). When a patient cannot travel they are seen on a joint visit by the nurse and doctor, at home if
appropriate. If the referral is urgent or there are special circumstances, the usual nursing assessment may be omitted and a joint assessment carried out at home or occasionally (e.g. if urgent admission has been requested) at the hospital. This team has continued with the policy of medical assessment in all cases except when the patient's own GP is satisfied that the Mental State does not need formal review and specifically requests Social Worker or Behaviour Therapy intervention.

The results of routine initial assessments are discussed at the Team Meeting and a care-plan is formulated. Decisions regarding urgent cases are made and care-plans formulated at the time of review.

Other Responsibilities
The team is responsible for the ongoing care of 40 patients in two long-stay wards at St Davnet's Hospital. A GP has recently been appointed to oversee the medical needs of this group.

Patients with special needs have been transferred to the service following discussion. Some patients under the age of 65 years have been accepted e.g. people with dementia, dual diagnosis of functional and organic illness or post-stroke depression. The same types of patient over the age of 65 years have often been transferred from the General Psychiatry teams after discussion on where their needs would best be met.

There is a regular commitment to the review of patients in EMI units. There are two Health Board Geriatric Hospitals with such units. Six private nursing homes have EMI residents.

Interaction with other Teams and Services
Areas of confusion surrounding the defined target population are resolved by discussion between the Co-ordinators of the three specialty teams.
Boundary issues have also posed problems at the interface between Community Care and Psychiatry. This was a particular problem when physically ill patients with delirium and dementia were being placed. Psychiatric placement has been requested inappropriately for patients requiring high levels of nursing support due to their physical status. The issue was discussed among all interested parties and the planning of a shared care unit is now at an advanced stage.

Future Directions
Future planning for the Mental Health Service for the Elderly relates to both facilities and service progress.

Facilities:
A Day Hospital attached to Cavan General Hospital.
A Unit for patients with dementia and enduring behaviour disturbance.

Service Progress:
Development of a Memory Clinic for the early detection of dementia.
Expansion of the Consultation-Liaison Service.
Increased involvement in mental health promotion.
A shared vision, held by the tripartite management team in Cavan/Monaghan, was fundamental to the rehaping of clinical services. Devolution of clinical management responsibility to the teams themselves has been central to their successful functioning. In addition to clinical leadership, the specialty teams require management by a clinically skilled individual. Specialist teams require, therefore, a clinical leader and a clinical team coordinator.

Clinical Leadership
The new specialist teams involve case sharing to a much greater extent than in traditional services. This is essential in the production of broadly based treatment programmes contributed to by the various disciplines. For sharing to be real, consultants need to be receptive to the legitimate views of allied professionals, while retaining ultimate clinical responsibility, which must always lie with the consultant psychiatrist. This requires consultant psychiatrists having special skills in encouraging real clinical input by team members.

Role of the Clinical Team Coordinator
The team coordinator needs to have an amalgam of clinical skills and management competence. Communication skills are essential, as is knowledge of team-building and coordination. The necessary skills, particularly clinical skills, make this role suitable for a senior nurse. In Cavan/Monaghan, these roles have been filled by former ACNOs and senior ward managers. The work of the Team Coordinator includes:

- Acting as central access point for referrals
- Liaison with GPs
- Liaison with outside agencies
- Coordinating teamwork
- Organising team meetings
- Coordination of inter-team activities
- Communications coordinator
- Monitoring agreed practice standards
- Data collection for audit
- Facilitating educational programmes for team members
- Keeping the clinical leader (consultant) informed of team activities and clinical problems.

The relationship between the team coordinator and the consultant is central to successful team functioning.

**Multidisciplinary Working**

Real multidisciplinary team working presents challenges to all the professional disciplines involved. Consultants will need to share appropriate responsibility for patient care. Likewise non-medical team members need to be prepared to accept this responsibility. This process is facilitated by team discussion and multidisciplinary input into formal care plans.

The clinical teams have responsibility for the management of their own specialty service. As providers of the clinical service, they have valid insights into the range of patient problems and treatment programmes that are required. They are responsible for setting up appropriate audit procedures, which include not only team activities but also evaluation of patient views and the views of referring agencies. The clinical teams are ideally placed to prepare annual service plans for submission to the Catchment Management Team.

**Clinical Governance**

Care management is the concept underlying the delivery of modern health services. At a clinical level this is expressed in clinical governance.
Cavan/Monaghan Mental Health Service this need will be addressed by the Catchment Management Team agreeing service programmes with specialist teams. These must be clinically effective, audited, and efficient in the use of resources. It is essential that specialist teams take ownership of agreed service plans and regularly review their successful implementation with Catchment Management.

**Information Management**

Information management becomes more complex in community-based, multidisciplinary team working. Detailed and accurate service activity information needs to be readily available for service audit and to guide future developments. Immediate availability of clinical data is required to facilitate individual treatment programmes. Clinical case registers have particular value in specific patient groups, such as those who pose special risks. Information management systems need to be adapted to meet these requirements.
8. EVALUATION OF THE NEW SERVICE

Evaluation of new services in mental health needs to take place over a period of several years. This evaluation should include clinical outcomes, use of resources, acceptance by patients, and benefits to personal, social and wider community functioning. Views of other service providers, particularly primary care, are also relevant.

Advanced Community Mental Health Services have been evaluated against standard hospital treatment in a number of international studies. In general, the results of these evaluations have not statistically established improved clinical outcomes, though the trends are in this direction. These model Community Mental Health services show superior improvements in patients' social and personal functioning. They are more effective than traditional services in reducing time off work and in retaining family and community ties. They are associated with a reduction in hospital bed-day use. At this stage in the new services in Cavan/Monaghan, evaluation is limited to an audit of service use, together with views of patients, carers and GPs. Given the recent introduction of the Mental Health Service for the Elderly, a formal evaluation is not yet completed.

In the setting of the specialist teams, all patients now have their individual needs assessed by a multidisciplinary team, aided by standardised needs assessment schedules. These assessments involve patient participation in agreed treatment programmes. In the Community Mental Health Team, adapted “FACE” schedules (Functional Assessment of the Care Environment) have been incorporated into patient case-files. In the Community Rehabilitation Team, in addition to the FACE schedule, use of the Community Placement Questionnaire for the remaining long-stay patients and the Camberwell Assessment of Need (objective and subjective components) for
community patients is standard practice. These assessments are necessary for the future evaluation of clinical outcome.

Patient Rights
Patients' rights are potentially most seriously infringed in the setting of compulsory admission to a Mental Hospital. Certification rates in Monaghan have declined substantially since the new service was initiated in 1998. (Figure 8.1) Certification rates in Monaghan, in 1999, were 31.8 per 100,000 population over 16 (12 patients) in comparison a national rate of 101.3. The Monaghan rate in 2000 was 34.4 (13 patients).

Figure 8.1
Certification Rates Per 100,000 Population

The reduction in certifications has been the result of a service that is actively involved in the ongoing care of psychiatric patients vulnerable to relapse. Further factors in the reduction have been improved access for GPs to the specialist teams, allowing early intervention, and the home-based locus of care supporting and reassuring relatives in dealing with acute relapse.
THE COMMUNITY MENTAL HEALTH TEAM

A specialty service for acute illness enables the concentration of resource for patients who need early intervention, quick response and rapid return to independent life. Such a service must utilise resources available in the community to a maximum extent in therapy. When illness is dealt with in the context of home and community, solutions are found in that context, institutional care is less relevant and isolation and stigma are diminished.

Referrals to the CMHT have been very predominantly from GPs. Some referrals were not thought to be appropriate. These referrals were discussed with the referring agent and alternative recommendations were made. The majority of accepted referrals are seen initially by a medical member of the team. (Table 8.1)

Table 8.2 describes the activity of the Home-Base Treatment Team for a two-year period from September 1998 to August 2000. Within the group of referrals to the Home-Base Team there is a sub-group of 14 patients who have continued on Home-Base Treatment for more than six months. This group do not fall into the category of acute mental illness but remain vulnerable to relapse because of non-compliance with medication and on-going social crises. Their needs are best provided for by being transferred to the care of a better-resourced Community Psychiatric Nursing service within the CMHT. The case-load of patients attending the Home-Base Team requires to be reviewed regularly to ensure that this resource remains targeted on individuals who are acutely ill.
<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>607</td>
<td>582</td>
</tr>
<tr>
<td>GP</td>
<td>522 (86%)</td>
<td>507 (87%)</td>
</tr>
<tr>
<td>First Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPD</td>
<td>390 (64%)</td>
<td>385 (66.1%)</td>
</tr>
<tr>
<td>HBT</td>
<td>67 (11%)</td>
<td>43 (7.4%)</td>
</tr>
<tr>
<td>Multidisciplinary Team Member</td>
<td>86 (14.1)</td>
<td>72 (12.4%)</td>
</tr>
<tr>
<td>Admitted</td>
<td>10 (1.6%)</td>
<td>4 (0.7%)</td>
</tr>
<tr>
<td>Inappropriate Referrals</td>
<td>43 (7.1%)</td>
<td>38 (6.5%)</td>
</tr>
<tr>
<td>Inappropriate Referrals:</td>
<td></td>
<td></td>
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<tr>
<td>Alternative Recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatry of Elderly</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>C&amp;A Psychiatry</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Bereavement Counselling</td>
<td>8</td>
<td>0</td>
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<tr>
<td>External MH Service</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Community Support</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Number of Referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>First Referral</td>
<td>158</td>
<td></td>
</tr>
<tr>
<td>Re-Referral</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
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</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia Spectrum Disorder</td>
<td>22.2% (61)</td>
</tr>
<tr>
<td>Depression</td>
<td>37.7% (104)</td>
</tr>
<tr>
<td>Mania</td>
<td>19% (52)</td>
</tr>
<tr>
<td>Neuroses</td>
<td>2.9% (8)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>9.8% (27)</td>
</tr>
<tr>
<td>Alcohol Detox Monitoring</td>
<td>5.5% (15)</td>
</tr>
<tr>
<td>Organic Psychosis</td>
<td>1.8% (5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Destination on Discharge from Home-Base</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD</td>
<td>67.2% (185)</td>
</tr>
<tr>
<td>Admission</td>
<td>13.1% (36)</td>
</tr>
<tr>
<td>GP</td>
<td>9.4% (26)</td>
</tr>
<tr>
<td>CRT</td>
<td>3.2% (9)</td>
</tr>
<tr>
<td>Unwilling to engage further</td>
<td>3.2% (9)</td>
</tr>
<tr>
<td>Still on HBT</td>
<td>2.5% (5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration on HBT (Days)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Mean Duration: 43 Days</td>
<td></td>
</tr>
<tr>
<td>(excl those 365+ days):</td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>134</td>
</tr>
<tr>
<td>31-60</td>
<td>78</td>
</tr>
<tr>
<td>61-90</td>
<td>28</td>
</tr>
<tr>
<td>91-120</td>
<td>10</td>
</tr>
<tr>
<td>121-150</td>
<td>6</td>
</tr>
<tr>
<td>151-180</td>
<td>5</td>
</tr>
<tr>
<td>180+</td>
<td>14</td>
</tr>
</tbody>
</table>
Patient and Carer Satisfaction

Patient, family and carer satisfaction with the Monaghan Home-Base Treatment Programme has been evaluated using the Verona Service Satisfaction Scale. (Figure 8.2) This is a self-administered questionnaire that assesses satisfaction with services on a five-point scale across seven dimensions: overall satisfaction, professional skills and behaviour, information, access, efficacy, types of intervention and relatives' involvement. The five points are 0-1 = “terrible”, 1-2 = “mostly dissatisfied”, 2-3 = “mixed”, 3-4 = “mostly satisfied, 4-5 = “excellent”.

Figure 8.2
Verona Service Satisfaction Scale

This study showed broadly-based satisfaction with the service provided, while suggesting areas for improvement.

GP Satisfaction

An evaluation of GP assessment of the new Community Mental Health Team and its Home-Base Treatment component was also carried out. A ten-item telephone questionnaire was used. The results showed considerable GP satisfaction with the new service programme. Criticisms were few. There was a request for more frequent clinical discussion with the Home-Base Treatment Team. Some GPs requested to have direct referral rights to the Home-Base Treatment Team with 24-hour availability. There was a suggestion that joint drug formularies be established.
The Monaghan Community Mental Health Service response to these suggestions was as follows:

1. It was felt appropriate that the Home-Base Treatment Team should communicate more regularly with GPs during episodes of treatment.
2. The Home-Base Treatment Team is part of the CMHT and takes referrals only from that team. Only in this way can services be prioritised for people with substantial psychiatric disorder.
3. While the CMHT is prepared to discuss the setting-up of an agreed drug formulary, it recognises that the priorities of the two services are different.
THE COMMUNITY REHABILITATION TEAM

Care needs of the remaining long-stay patients

The consequence of the specialist care programmes for those with persisting mental illness has been the progressive provision of more appropriate treatment programmes based outside the hospital. The placement and treatment recommendations of the small residual population are shown in Figure 8.3. Patients in the specialist geriatric category are characterised by physical illness or frailty and substantial psychiatric illness. Investigation of their needs suggests that they are best cared for in a non-mental hospital setting with combined inputs from Psychiatry of the Elderly and Geriatric Services.

Figure 8.3

Placement Needs of Long-Stay Patients in St. Davnet's Hospital
1979, 1995, 2000

Staffed Hostel Use

A review of staffed hostel placements shows that this population is not static. The needs of residents change and are often more appropriately met in other care settings. Since the opening of the last hostel in 1996, there has been a 50% turnover of staffed hostel places. With the advent of the Assertive Outreach Team, however, the majority of the "new chronically" ill have not required
staffed hostel placement, but have been maintained in their own homes. The provision of a further 16 placed hostel for the remaining graduate population will give a staffed hostel resource of 66 places per 100,000 total population. With the working through of the cohort effect of the graduate population and the further development of Assertive Outreach Nursing, it is envisaged that no additional staffed hostels will be required.

**Inpatient Bed Use of Patients of the Assertive Outreach Team**

Since the advent of the Assertive Outreach service in late 1998, the inpatient bed requirement of patients transferred to the service has fallen substantially. **Figure 8.4** below illustrates the bed occupancy of the first 30 "new chronically ill" patients transferred to the service.

![Figure 8.4](image)

Bed Occupancy of Patients Before and After Transfer to the Assertive Outreach Service

**Needs profile of community-based patients with enduring illness**

Investigation of the care needs of a group of 67 patients with enduring illness, living in the community, is described in Table 8.3. The results confirm that this population have multiple problems associated with their illness. They highlight the need for ongoing specialist care programmes targeted at persisting symptoms together with social, vocational and personal care needs.
Table 8.3
Needs Profile of Community Patients

### Clinical Needs

<table>
<thead>
<tr>
<th>Area</th>
<th>NUMBER</th>
<th>% of pts.</th>
<th>Unmet</th>
<th>Unmet</th>
<th>Unmet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Symptoms</td>
<td>46</td>
<td>65%</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Positive Psychotic symptoms</td>
<td>42</td>
<td>61%</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Neurotic Symptoms</td>
<td>35</td>
<td>52%</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Side-effects</td>
<td>17</td>
<td>25%</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Distress</td>
<td>13</td>
<td>19%</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Destructive Behaviour</td>
<td>9</td>
<td>13%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Embarrassing Behaviour</td>
<td>6</td>
<td>9%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slowness and Underactivity</td>
<td>2</td>
<td>3%</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Organic Brain Disease</td>
<td>1</td>
<td>1.5%</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

### Social Needs

<table>
<thead>
<tr>
<th>Area</th>
<th>NUMBER</th>
<th>% of pts.</th>
<th>Unmet</th>
<th>Unmet</th>
<th>Unmet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation</td>
<td>32</td>
<td>48%</td>
<td>9</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Personal Hygiene</td>
<td>29</td>
<td>43%</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Manage Affairs</td>
<td>22</td>
<td>33%</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Money Management</td>
<td>20</td>
<td>30%</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Household Chores</td>
<td>16</td>
<td>24%</td>
<td>8</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Get Meal</td>
<td>12</td>
<td>18%</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Household Shopping</td>
<td>11</td>
<td>16%</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>5</td>
<td>7%</td>
<td>1</td>
<td>0</td>
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</tr>
<tr>
<td>Education</td>
<td>4</td>
<td>6%</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Public Transport</td>
<td>3</td>
<td>4%</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Public Amenities</td>
<td>3</td>
<td>4%</td>
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</table>

### Total Needs

<table>
<thead>
<tr>
<th>Area</th>
<th>Total</th>
<th>Unmet</th>
<th>Unmet</th>
<th>Rx</th>
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<tbody>
<tr>
<td>Clinical Area</td>
<td>170</td>
<td>25</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Social Area</td>
<td>155</td>
<td>37</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>325</td>
<td>62</td>
<td>45</td>
<td>17</td>
</tr>
</tbody>
</table>
EFFECTS ON TRADITIONAL PRACTICES OF THE NEW SERVICE MODEL:

Since the introduction of the new service model in late 1998 there has been a dramatic fall in the use of inpatient beds. This is shown in a marked reduction of admissions (Figures 8.5, Figure 8.6), readmissions (Figure 8.7) and occupied bed days (Figures 8.8, Figure 8.9, Table 8.4). Certification rates have dropped to a quarter of the national rate (Figure 8.10). Use of ECT has halved (Figure 8.11). The effects of these changes raise basic questions relating to the legitimacy of traditional hospital-based psychiatric services.

Figure 8.5
Admission Rates (All) per 100,000 Population

Figure 8.6
First Admission Rates per 100,000 Population
Figure 8.7
Readmission Rates per 100,000 Population

Table 8.4
Daily Numbers in Admission Unit

<table>
<thead>
<tr>
<th>Year</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>9-20</td>
<td>6-16</td>
<td>1-13</td>
<td>1-8</td>
</tr>
<tr>
<td>Mode</td>
<td>15</td>
<td>13</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>16</td>
<td>12</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
Figure 8.9
Total Occupied Bed-Day in St. Davnet's Hospital

Figure 8.10
Certification Rates Per 100,000 Population

Figure 8.11
Completed Courses of ECT Cavan/Monaghan
Rate per 100,000 Population
Irish psychiatric services emphasise hospital care. As a result, Ireland has high hospitalised morbidity and high rates of admission to inpatient units. Similarly, Irish certification rates are very high in comparison to equivalent jurisdictions.

The move to community care has been progressive but has been reflected predominantly in the reduction of long-stay populations. The discharge of long-stay patients to group homes and hostels, however, has often been a relocation exercise rather than being planned, supervised and supported by a specialist rehabilitation service. In this way, on-going treatment and further rehabilitation has often not taken place. The Community Rehabilitation Team in Cavan/Monaghan has demonstrated the specialist care needs of this group and the extensive resource required for their care. It is suggested that each mental health service should develop a specialist service for the severely mentally ill.

Community alternatives for the treatment of acute illness in crisis have been much slower to develop. The failure to develop these services has occurred despite the evidence of their improved effectiveness. Clinical outcomes are at least comparable with traditional services. The Community Mental Health Team, with its Home-Base Treatment Team, has demonstrated its ability to provide effective community-based alternatives to inpatient care in the management of acute illness. The establishment of similar services elsewhere in Ireland should be considered.

Developments in Cavan/Monaghan have shown that novel services can be established given vision, commitment and management expertise. Financial constraints are not of central importance. Most catchment services in Ireland
have substantial numbers of staff with the clinical skills required for these new services. At the moment much of this resource is tied to the residuum of mental hospitals.

Priority needs to be given to hastening the closure of traditional mental hospitals, with the release of staff and capital resource. In Cavan/Monaghan the closure St. Davnet’s Hospital has been accelerated by the establishment of a specialist rehabilitation service.

**Acute Inpatient Units**
The dramatic reduction in acute bed use in Monaghan has major implications for current planning for acute units in General Hospitals. The maximum acute bed requirement in Monaghan throughout 2000 was eight for 54,000 (mode=2). Units of this size can be provided in specialised hostel-type accommodation (“crisis house”). Alternative planning would be a 16-bed unit (15 per 100,000) in Cavan General Hospital to accommodate the acute bed requirements of the three specialist teams in the catchment. The “crisis house” option is favoured by the management team. Given the geographical size of the area such a facility would permit greater integration with community-based services and allow for the provision of a more normalised therapeutic environment.

The Cavan/Monaghan experience suggests that current planning norms for the provision of acute psychiatric units in General Hospitals should be radically reviewed.

**The Disturbed Mentally Ill**
A group of patients who present special problems are those who have enduring disturbed and challenging behaviour in the context of mental illness. It is the view of the Cavan/Monaghan Catchment Management Team
that these patients require care in a specialist unit. Given the numbers of patients involved, such a unit is best provided for on a regional basis.

Implications for the Mental Health Act
A clear consequence of the new service has been a very marked reduction in certification rates, to one third of the national rate. This fall has enabled greater respect for the civil rights of patients. The low level of certification, if applied nationally, would have major implications for the work-load of the new Mental Health Tribunals.

Catchment Size
A significant factor in the successful reorganisation of the Cavan/Monaghan Mental Health Service has been the lack of fragmentation between the different specialty teams. Catchments of 100,000-150,000 are ideal, in that they minimise such fragmentation. They facilitate staff knowledge of and familiarity with the total service and enable good inter-team relationships. At the same time, they allow appropriate population size for specialist teams.

Sector Size
The document "Planning for the Future" recommended sectors of 25,000, served by one general psychiatric team. The Cavan/Monaghan Community Mental Health Teams have target populations of 50,000 (two sectors). This enables adequate provision of full multidisciplinary teams and has the advantage of allowing the service to be provided in a cost-effective manner. The specialist services of Rehabilitation Psychiatry and Psychiatry for the Elderly require a larger population base and in Cavan/Monaghan these are catchment services.

Initiation of New Services
The Cavan/Monaghan catchment is predominantly rural and does not have the problems associated with urban conurbations. Illicit drug abuse is
relatively low, as are levels of homelessness. However, it is not unlike most other areas of rural Ireland. The principles applied to the reorganisation of the Cavan/Monaghan services can be applied to all regions. These are:

- The development of specialist services for particular patient groups
- The centrality of patient's needs and rights
- The delivery of individualised effective treatment packages in the setting of home and family
- Minimum use of inpatient beds

In Cavan/Monaghan the sequence of service reorganisation was the development of a specialist service for those with enduring illness (the Community Rehabilitation Team) followed by the setting up of Community Mental Health Teams and finally, the specialist service for Psychiatry of the Elderly. This sequence has been valuable in releasing resources formerly tied up in the mental hospital.

Each of these specialist services have individual merit. Their implementation should reflect local priorities. The establishment of pilot projects is a useful option in initiating service reorganisation.